Bayer

Bayer Corporation
100 Bayer Boulevard
PO Box 915
Whippany, NJ 07981-0915
862-404-3000

Physician Information
Name: _____
License No: _____
Address: _____
_____
Phone: _____

Shipping Address
Contact Person: _____
Address: _____
_____
Phone: _____

Additional shipping addresses may be listed below and/or in an attachment.

To: **[Customer Name]**

The undersigned physician certifies that he/she (a) is affiliated with the shipping location identified above and any additional shipping locations listed below and in any attachments, (b) will be responsible in all respects for the receipt and accountability of pharmaceutical products shipped to such location(s), and (c) will immediately notify Bayer if either of the foregoing statements is no longer true.

This certification and authorization does not apply to shipment of controlled substances.

(Optional) I authorize the following representatives to accept and be responsible for pharmaceuticals delivered to the shipping address(es):
Print Name(s):

PHYSICIAN SIGNATURE REQUIRED (must match name on license):

Signature: _____
Print Name: _____ Date: _____

NOTE: **You MUST submit:**

- A copy of a valid license reflecting the license holder's name AND
- Evidence that each shipping address is your medical office (acceptable evidence includes a business card or letterhead that reflects your name and office shipping address).

Additional Shipping Addresses (optional):

Shipping Address:

Name of Location: (if different from above) _____

Address: _____

Contact Person: _____
Phone No.: ( ) _____

Shipping Address:

Name of Location: (if different from above) _____

Address: _____

Contact Person: _____
Phone No.: ( ) _____